Preparing Our Children To Learn: A Supplemental Report

Assembly Select Committee on California Children's School Readiness and Health

Assemblywoman Wilma Chan, Chair
August 2002

Purpose of the Select Committee

The Select Committee was established in 2001 to examine the relationship between the status of children's health and its impact on school readiness and achievement. The Select Committee works from the premise that a healthy child is more likely to come to school ready to learn and able to succeed in meeting the State's rigorous academic standards.

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Dear Reader:

On behalf of the Select Committee on California Children's School Readiness and Health, I am pleased to provide you with this supplemental book to the March 2002 report ***Preparing Our Children To Learn***.

This supplement includes key testimony which was presented at the Committee's 2001 hearings held across the state. This insightful and engaging testimony, from some of the state's best thinkers on children's school readiness and health, will provide you with a context for the recommendations found in our March 2002 report.

The testimony is listed under specific topic areas: Seamless Services for Children and Families, Physical Health, Dental Care, Improving Access to Health Care and Coverage, Mental and Emotional Health, Early Childhood Assessments, and Nutrition. Please note that in order to maintain the integrity of the testimony, it has been edited for grammatical purposes only.

At the conclusion of this publication you will find an example of pending legislation which is designed to address many of the issues and concerns raised by our hearing panelists and participants.

Thank you for your interest in children's school readiness and health. We hope you find the information in this supplemental book useful. Please feel free to contact the Select Committee directly should you wish to learn more about its current activities.

A special note of thanks goes to Wanda Hasadsri, Karen Dea, Judith Klinger, Rachel Richman, Joycelyn Martinez-Wade, Oscar Joseph Daly and Julie Hadnot for their work on this supplemental booklet.

Finally, the Select Committee would like to thank every one of our panelists who presented at our 2002 committee hearings. The Select Committee's report, ***Preparing our Children to Learn***, would not have been possible without the generous gift of their time, talent and wisdom. While we were unable to include every testimony given during our hearings, we do have on file the tapes of the proceedings. A list of all panel presenters can be found at the back of this supplemental booklet.

Sincerely,

Wilma Chan, Assemblywoman
Chair, Assembly Select Committee on California Children's School Readiness and Health

I. Seamless Service for Children and Families

Mary View-Schneider, Co-Director of UCLA's Center for Healthier Children, Families and Communities
Thursday, November 8, 2001 – Culver City, CA
Good morning. My name is Mary View-Schneider and I'm an assistant director at the Center for Healthier Children, on loan from Los Angeles Unified School District where I taught kindergarten and pre-K for 15 years. So my context is as a teacher who had the same feelings that you mentioned. We need to recognize children and families in need, but until there's a system that really links communities and schools together, teachers and others are left without resources.

So I have the pleasure today of talking about the school that I was at, and your handout has an apricot cover, if you're looking for it. It's the kindergarten teacher in me, to color-code things.

This is a school that had a population of about 3,000 kids, pre-K through 12th grade, in the city of Cudahy. And the reason Carol and I are here to talk together today, is because this is a school that, because it was grounded in a school reform movement in 1991 that was a partnership between a non-profit, the Los Angeles Educational Partnership, the school district, and the United Teachers -- Los Angeles under Helen Bernstein, looked at schools in a different way. And we became the first site of the Urban Learning Centers of the new American schools.

And what we said is, looking at our school reform movement, is that most standard school reform movements only looked at changing curriculum, instruction, and changing the way schools are managed. And with the work of UCLA and Dr. Howard Adelman and Linda Taylor, we were made aware that children who come to school, obviously any teacher could have told you this, or any school nurse or school mental health provider, that you can have great curriculum and instruction, you can have strong management, but unless we address those barriers that children in poverty (whether they live in urban or rural communities), which have no access or little access to health care, mental health services, and provisions for family support, we can't change the way children learn without supporting that.

So under Howard Adelman's model that we adopted, we looked at six programmatic areas that we would address as a third of our concentration on our school reform, and part of that was home involvement in schooling -- how we involve the parents and families in the school -- and student and family assistance for those students and families really have needs -- how to provide that. And we were able to develop a partnership to provide some of the needs.

And Carol and I are going to just go back and forth here.

Carol Valentine, Elizabeth Learning Center
Thursday, November 8, 2001 – Culver City, CA
Well, in part, what really enabled us to focus on this idea of reducing barriers to learning, was the fact that the school could allocate resources under this grant for the creation of a position, which is the Family Center Director, and a space, which is our Family Center, as a base of

operations. We looked at this as a hub for community services, although when we began we had no services, we had a room and we had a position and we went looking for community partners to help mitigate some of the barriers in this community.

This community is one of the poorest in the country, we have 100-percent qualification for free lunches, it's incredibly overcrowded, it has all of the risk factors that poverty entails. And so beginning our work as a hub for community services, we worked very closely with the community and the parents, we did extensive needs assessments. We found that, not surprisingly, one of the big issues for the parents was education and access to education. Over half of our parents in our community had sixth-grade level or less, and they wanted a chance to be able to assist their children.

So what we basically began creating, was a parallel process for education for the parents at the school. And we looked for a partnership with the Division of Adult and Career Education in Los Angeles, and we were able to put together a model. Basically, you could loosely say a family literacy model. We had tremendous support from the Parent Education Department and from our local adult school. And we now offer over twenty classes during the day, we have a parent cooperative child center that our parent educator helps coordinate with volunteers, and what we actually envision happening is that we also have an extensive Head Start Program and State pre-K program.

We knew that parents in our community were stressed. They may be working two jobs, three jobs. If they were going to have a shot at learning how to help their kids, it had to be when they could access the services. And to that end, we've tried to provide these classes from nine o'clock in the morning to nine o'clock at night, with appropriate child care. And for example, if a parent whose community starts taking an ESL class when their child is one, by the time their child is five, the child will have gone through four years of developmentally appropriate preschool experience. The parent will be bilingual and will be obtaining their high school G.E.D. And the parent will also have had four years of parenting classes so he knows very well nutrition requirements for their kids, developmentally appropriate parenting practices.

So this type of model is really intensive and it's not short term. But fortunately, there are funding streams that are available for this model, schools can look to collaborate with existing Head Start programs, State pre-K programs and the adult division. But where we really don't see this being replicated is the fact that there's no glue money available. If schools can't allocate funds to have personnel to help coordinate, if the collaborative agencies can't put some money into coordination, it doesn't work. It just becomes something that's stuck out at the end of the bungalow somewhere.

So it really needs, basically, glue money. How do you get these agencies to work together strategically to address the needs of their population? You would probably see more formal family literacy programs except none of the existing funding streams support that, even though the Workforce Education Act, and Adult Education Act, and Head Start all are asking for family literacy. Family literacy requires four components, one of which is parent and child interaction time, which is called PAC time or possibly you'd hear it as child observation. But none of our funding streams pay for these parents and children to come together.

Mary View-Schneider: When we started this business I was teaching pre-K and we had sixty kids in the district-funded program. Within one week of enrollment, I cut off my waiting list at 100 kids. We knew there was a vast population of children in that community who needed early child education. So Head Start brought a million dollars to the building, to the schools, and we expanded our program to have six more additional early childhood programs funded through the State preschool.

But this was only because at this school, parents and teachers and the community worked together and identified the needs. But of course one of our biggest needs was health care. Because our families are largely undocumented and very poor, they had no health care. They only used emergency rooms for their episodic care.

So with a grant with Cal State Dominguez Hills and St. Francis Medical Center, we were able to create a school-based health clinic, which the first year of operation took care of all of our children, whether they had health insurance or not, and they still continue to do that. They provide OB/GYN services, family health services, pediatric care, well-baby care, CHDP *(Child Health and Disability Prevention)*, health and nutrition, and also mental health.

The Family Resource Center provides additional mental health services in partnership with university interns and the school district paying for a social/psychiatric worker out of Title I funds. So over a period of nine years we've created a fairly rich, not rich but in terms of money but in terms of services, for our families when there was none.

But like John says, "we always struggle with can we get enough families enrolled" so St. Francis can keep their doors open? -- and they've been so good at that, underwriting so much of what we serve. They see 400 clients monthly who would not be seen before this. Of course in our community, dental care, asthma, diabetes, and childhood obesity are the big problems, but because we have a health clinic on campus, and we have a consultation case panel that brings the school district people, our mental health providers, and our health providers all together to talk about children and families who are referred in context of child and families, we are able to do a much more, thereby creating a medical home for our children.

But the issues that our medical providers face are the same issues that Neal Kaufman referred to. St. Francis so generously underwrites so much of what they provide because our families do not qualify or because it's so complicated some of our families have to go through four different systems so all members of the family are covered.

These are people with third, fourth grade education, they give up before they even start. We sit there and help as much as we can, and certainly LA Unified *(Los Angeles Unified School District)* provides a lot of outreach, St. Francis does, but when you're talking about three thousand kids and their families, we could have full-time outreach workers. So we have to look at this issue of multiple qualifying for families.

But it's important to look at schools as one place, I know you're going to talk about Hope Street which is another one of my very favorite places in all the world, because it's a place where

children and families are seen in context with other families, and where services are brought to one place. Because in our community families cannot even go a mile down the road; there is no transportation in Los Angeles, let's face it.

So our outcomes for our schools are -- we have improved in terms of academic success. Our high school kids have a 47-percent passage rate on the high school exit exam, and our neighboring schools have about 20 something. Over 90-percent of our kids go to college upon graduation.

But we are always struggling for funding, always struggling for that glue money. Carol and I can be at Elizabeth that one day a week to help support the work there. But the key to success is that you can deal with families in their context, and you can provide a system that will improve academic performance if that's one of our outcomes we have to look at.

But more importantly, we're saving kids' lives. I can tell you, because the school-based health clinic directly triages from the school nurse's office, we've had kids go into diabetic comas on campus and be able to triage them directly into a full service clinic. There's really no way to document the number of children and families we save by early diagnosis. These are families that previously used the emergency room for care. But we know it's in the hundreds.

So it's a way we can do it, whether we use a hospital-based system or a school-based system, or strong CBO's as partners, we have to bring services to where children and families are, and we have to simplify the process.

Dr. Jackie Kimbrough, Executive Director, The Children's Collective
Thursday, November 8, 2001 – Culver City, CA
Good morning. I'm Jackie Kimbrough. I'm director of The Children's Collective, which is a private nonprofit child development corporation in South Los Angeles. And I'd like to speak a bit this morning about the role of the child development center in school readiness. We've heard a bit about the public schools, we've certainly heard about traditional medical institutions. But from our experience in South Los Angeles for about the last thirty years, we feel the child development center is a very important focus and locus of school readiness efforts.

The Children's Collective for the last thirty years has provided child development and family support services. Currently, we serve about three to four thousand families in a variety of programs. Initially, we did just child development. But as the nature of poverty changed, as the economy changed, we found that children who traditionally had insurance because their parents were employed in industrial jobs, now have parents employed in service sectors and they have no insurance and they have few other resources.

So to address that lack of resources, in addition to the basic child development program, we have sought and received city funding for our family development network. And that family development network is designed to help parents achieve financial and emotional stability, so that they can provide their kids with a much more supportive and nurturing environment.

That has been an extremely important program for us in promoting school readiness because many of the parents' circumstances as I'm sure you're all aware of, are difficult. There are difficulties in getting the kids to the doctors, there are difficulties in getting money from the social workers and social service systems, and the children are obviously affected by all those circumstances.

We have a case management system through the Family Development Network, that provides for the families literacy training, financial support, physical and mental health services, substance abuse treatment, as well as violence prevention services. In addition to that to support our families, we sought Proposition 10 funding and were able to bring into our child care center on a mainstreamed basis, developmentally delayed children who otherwise really didn't have very many options in terms of preschool and activities of preschool nature.

Additionally, we brought in services for integrated physical, mental, dental issues that children in our community were having. So the Prop. 10 program and the family development network were both observed as very, very important sources of support to the families as well as the children. And in working in those programs, we've discovered several, that we consider best practices for the families.

The first best practice is that the earlier we're able to reach the children, and we do take children as young as 2 months old, we feel the more likely we are to have positive outcomes, both health-wise and totally developmentally.

We also find one of the best things we can do is provide multiple, integrated services in a seamless system. And what I keep hearing today is talk about glue, what holds it all together. One of things that we're doing is case-managing each of those services. So we have social services, we have a variety of health services, we have literacy services. But the most important thing probably to that whole system, is the three or four people -- well, the network of people -- there are three or four managers, but the network of people from infant development specialists to the people who work with the CHDP vans, who actually coordinate the services across all the children.

And again the most important thing about this, as a best practice, is the service coordination. Not the fact that multiple services are offered, but that those services are coordinated in case conference, and a treatment plan for each child is established and followed up on. So that's for us the key to best practice.

The other important issue for us, is that because we're a child care center, we're able to provide families with information. We see the parents on a daily basis, two or three times a day sometimes. So in many situations where there's limited access to parents, the child care center actually provides ongoing access to parents, and that's really, really a crucial aspect of child development.

We have found overall that the center itself is a crucial link. And one of the reasons it's such a crucial link is that parents find child care centers to be very user friendly. On some of our services, our mental health services in particular, parents feel stigmatized by group therapy, by

any of the things being done with their children. And they have been very, very resistant to any of the referrals outside the system, outside our child care system.

What we have been able to do is offer on-site therapeutic services to the children, and the children provide an entry and access to the parents. And as they do that, and as we have observed this process working over probably the last year, it's just become more and more apparent that the child care center, like the school, is a natural locus and focus of many of these services

Now we hear frequently about how under-served we are in the child care community, and we are indeed. I think there are probably only about 100,000 children, poor children, in subsidized and licensed care. And there are 900,000 additional slots for which children are eligible, but the space and the money is not available.

But if those spaces were made available, and if the money were made available, the child care center itself could certainly serve as a very, very central focus simply because the children are there everyday so you have the efficiencies of the presence of the children in the facility. Some facilities are small -- ten to fifteen children. Many facilities are a hundred children, a hundred fifty children. So you have a hundred fifty children there everyday, or a hundred children, fifty children, that you can provide, or that a medical provider or a service provider can actually provide services to. You've got parents there who are very supportive. You can have multiple types of services in the same location, so again there are efficiencies of scale there that I think should be taken advantage of.

The child care center could also address many non-health related issues for school readiness, and those have to do with the transition of children, shortening that time, doing different kinds of assignments in the classroom to increase the children's attention span, and to prepare them for the public school experience.

But most importantly, in terms of what it is that agencies like ours need, the first thing is resources that are a bit more flexible than they currently are. Most of our resources are categorical. Most of our funding is child development funding from the State Department of Education. That funding really does not provide enough money, enough actual dollars, for us to provide the ongoing mental health services and physical, dental, and vision services that we have.

Prop. 10 itself, as I say, is a best practices model, because it does allow us to provide those services. So what we would encourage most of all is increased funding so that agencies like ours can provide the additional services that are needed, as well as increased collaboration among different types of service providers.

Thank you.

II. Physical Health

Parent Testimony
Thursday, November 29, 2001 – Salinas, CA
Good morning everyone. I live in Salinas and work at Jesse Sanchez Elementary School. My position is school secretary. My family and I immigrated from Mexico in 1975. Most of my family has worked in the fields, including myself. We have lived in the Salinas Valley since 1975. So we are very well-acquainted with the environment and the people here in Salinas.

Thank you for giving me the opportunity to participate on this panel. I would like to share with you my personal experiences and experiences I have witnessed at my place of work, explaining the need of good health care for our children.

In October 1999 my son, who was seven years old at that time, got a severe skin infection. Because I had a very demanding job, I did not pay attention to his condition causing him to have lost weeks of school. The other factor was I had a very small or minimal medical plan that did not cover visits to the specialist.

He did not qualify for Medi-Cal or any other medical services due to the fact that our income was too high to qualify but not enough to pay his medical visits. Finally, I took him to a specialist, with whom I made arrangements to make monthly payments. My son still has several scars on his legs, arms, and lower back from scratching too much. I waited a little too long to take him to a doctor.

In 1999, my daughter who was four years old at that time was not succeeding in school for some reason. Her teacher said she was maybe not mature enough to be in school or she had a learning problem, possibly she was maybe lazy. I kept pressuring my daughter to pay attention to her teacher and concentrate in class. She got to a point where she did not want to go to school anymore. She was very frustrated, as much as I was.

Five months later after giving my daughter many difficult times, the school nurse did a routine vision screening which she failed to pass. The nurse sent me a letter at home advising me to take her to an optometrist. I took her right away since I have a very good vision plan. Yes indeed, she needed glasses. My daughter was able to do much better in school after she got her glasses. She was very happy to see well. We all discovered that she didn't have a problem, she just needed to be able to see well in class.

As a school secretary, one of my responsibilities includes taking care of the nurse's office when the health agent is not available. I have witnessed many cases where children come to school in very poor health. In March of 2000, a student by the name of Anna, a second grade student -- I'm giving her a different name to protect her identity -- had a severe eye infection for several weeks. She was in the nurse's office almost everyday, hoping the nurse would be able to do something for her. We made several phone calls to her house, spoke to Mom many times, begging her to take Anna to a doctor.

Mom did not have any medical plan or coverage. She just applied different kinds of eye drops that she got from friends or from the pharmacy over the counter. Finally, we convinced Mom to take Anna to the doctor. Because Mom waited too long, several weeks, Anna lost her vision in her right eye. Not only that, now she has a very noticeable scar on her right eye. This was totally wrong, Anna was embarrassed to come to school knowing she had a funny looking eye. Anna was almost retained in second grade, she was very behind in class. Thanks to her wonderful teacher she was promoted to third grade. But she had lost lots of days of school.

I could continue giving you many other examples that break my heart every time I remember or think about them. If I may, I would like to suggest the following:

> To develop strong methods to teach, inform families, educators, school nurses, school administrators, authorities, and the community in general how vital it is to provide every child the opportunity to grow strong and healthy. Good health is a vital part, if not the most important, in the life of a person.

Anyway, these students will be parents, educators, and maybe government officials in the very near future. We'll need to work together to provide our children a more healthy environment, and have access to good health care services. We all deserve a healthy start.

Thank you.

Bonnie Gutierrez
Thursday, November 29, 2001 – Salinas, CA
Good morning, I'm Bonnie Gutierrez and I'm a pediatric nurse practitioner and I coordinate the health services and Healthy Start program services in the Pajaro School District. Our school district serves almost 19,000 students, covering both South Santa Cruz County and North Monterey County. Our district ranks 20th in the State for LEP (Limited English Proficiency) Students, 53-percent of our students are on free and reduced lunch, 37-percent are migrant, and over 60-percent of our families work in the agricultural industry.

Our community has a federal designation of medical service shortage area, our Latino population has been designated as a medically underserved population as there are areas of shortage in primary medical care providers.

The students in our district in reviewing our health problems list last year, and this is the general population of students, we have a SELPA (Special Education Local Planning Area,) so there's a lot of other kids in special education, but just looking at the general health of our students, we found in dental decay, there were at least 2 students per classroom with abscess and decay and pain. We have almost 1500 students that require glasses, yet many of the students lose their glasses, they break, and many of them don't want to wear them because other kids tease them. We have 1300 students with asthma, 94 students with seizures, and at least 28 students that we know of that have childhood diabetes.

Our pre-kindergarten students come through a registration program called the kindergarten round-up. It's a welcoming environment, but it's an area where we can screen the students and get early identification of health issues, so our kindergarten teachers are there, our school nurse, our speech therapist is there, to assess them. Last year out of 1,024 students that entered kindergarten, 880 of those students went through our round up, and we found 1 in 4 of those students having significant health problems -- asthma and allergies being the most prevalent problem, out of the 805 students that were screened for dental decay, one fourth of those students had untreated decay, and half of those had class 3 and 4 abscess and decay. Thirty-two-percent of those children have no dentist, and sixteen-percent had no health insurance.

Health issues of the children in our rural area have issues where families in agriculture are working long hours and with low pay and really not knowing the access to services that may be in the community. That in turn delays their care and increases the health problems until they become acute and sometimes devastating to the child's health.

Environmental factors are a big issue in our community. We have a lot of methyl-bromide, a lot of pesticides, and we have a high incidence of asthma which in turn is going to relate to attendance issues for our students.

Housing is always a big problem. Myself doing home visits years ago, I found in three-bedroom apartments there were three families living there. Now we're finding that even the bathroom and the kitchen are rented out for people to come and use. And driveways are rented out for parking cars that families live in. So this in turn increases the rapid transmission of illness. And I don't know how any child could begin to study and learn and do homework in an environment like that.

In our district we are fortunate to have a unique combination of services. I coordinate all the health services and have increased nursing staff so that we now have fourteen school nurses. The nurses do vision and hearing and dental screening, they identify communicable diseases. I really encourage preventive health education that goes on from kindergarten on, and they serve all the special education students there.

Our Healthy Start Program started in 1992 with three of the original forty grants that were given and we've continued that program on other funding and have now last year started a district-wide approach where we have a children's resource center serving all the elementary students, and a teen resource center serving all the middle and high school students.

In our centers we provide free CHDP immunizations, free dental services -- and that is cleaning, sealant, fluoride treatment, and remediation (the drill and fill is what I call it). We provide insurance sign-up for all the types of insurance and a lot of information referral, and I got a van because we need to help families with transportation.

We also identified that lice was a big issue and I implemented what I call the lice-buster program where you don't just send a letter home. On the second day of the child being out, we call home. We say "Do you need help?" I bought vacuum cleaners, I bought lice combs, I bought the shower caps and all the equipment so that we can go out into the home and help the parent.

And they cry when we go out and help because they need that help. We've found that by doing that, I have found students who were out for thirty days or more due to head lice. And at the end of last year, our district-wide stats came down to an average of two days out.

We also request that the parents have a school entry exam and we can offer it to all the preschoolers, because we know that's going to help us find out the health status of that child and begin remediation. We were fortunate in our district to receive funding from Monterey County and now Santa Cruz County and I have a Prop. 10 preschool nurse (I call her my frontier woman). She is going out into the preschool programs that funnel into our district, working with those programs, identifying parents and children that need our services because they don't have insurance and coverage in other ways, bringing them in, getting those services, and then she case manages the students that have health issues identified at the round-up and then gets them resolved prior to them entering kindergarten. It's really working; it's a very exciting approach.

And in February of this coming year we are starting a pilot enrollment center where my children's resource center is next door to a language assessment center, so we're going to be having families, not the kindergartners, but the other students come in from three elementary schools and a middle school to look at, support with all those enrollment papers and the free and reduced lunch forms, and getting their language adequately assessed and students placed in appropriate programs, and then they'll be coming in to our Healthy Start center for their shots, for their health exams, for their dental services, and any other resources they need.

The problem that I see where we are really lacking is one of the biggest -- mental health issues. You know when you have families living in such poverty, there's a lot of dysfunction. Last year we had, and I know we still have them, five students that are selective mutes, some in kindergarten, some as high as fifth and sixth grade, that will not speak in class. They can speak on the playground, they can speak at home, and there is no mental health services. I went from our local community-based organizations, to our county mental health, up to Stanford, and I found nothing to provide services for these children. We had two students in elementary schools attempt suicide last year. So the need for mental health, language appropriate mental health services for students and families is sorely lacking.

Nutrition is another important issue. If you're living in your car, if you're renting, it made me realize why I was hearing from teachers that when they do nutrition education now the kids are not saying I eat beans and rice at dinner, what they're saying is I eat Top Ramen for dinner. Top Ramen: all you have to do is boil water, and you're done. But Top Ramen is not going to help brain development of these children. And obesity is going to be another side factor to that, which then in turn leads to diabetes.

Dental again, a big one. Many of our kids are coming with bottle mouth syndrome. This could be prevented rapidly if there was early education. And also, the cost to access to treatment is appalling. People know that and they know their kids need help -- but they can't afford it.

I think some of the universal mandated services we need -- CHDP's (Child Health and Disability Prevention) exams are free -- but often there is no money to cover the follow-up treatment. So it

doesn't help to know that your kid has dental abscesses if there's no money to provide the following treatment that needed to happen.

The other one that's dear to my heart is developmental readiness for kindergartners. I think now, more than ever, we have such an academic push in kindergarten, it's not like when I went, and we napped and we ate cookies and milk. And many, especially boys, are not ready yet to start kindergarten, and it just sucks them up in a spiral where they can't sit and learn, they still need to move. So we need to look at more developmental kindergarten classes where they have the time to begin to develop that first year and then maybe go into academics. Because when you start holding them back it creates esteem issues, it creates all sorts of identifying issues, and kids don't then go on to do well in school.

The other issue near to my heart is the Healthy Start programs. We hear the State is not funding new ones. These are school-based, school-linked programs that provide on-site services for our children in our schools. It helps fund more school nurses, it helps fund social workers that can do a lot of work in the schools. Our Pajaro School District is fortunate, we've been serving 10 years now through Healthy Start and district-wide services partnering with a lot of the nonprofits and county agencies who have redirected their services to the schools. We created the centers, they redirected their services. We blended funding, which I call dialing for dollars. I look for grants, we fund with general funds through the district, we do LEA Medi-Cal billing, we do Medi-Cal administrative claiming, our Categorical Director works with me on Title XI funding from the federal government. And those are ways that we've been able to affect and serve our 19,000 students, and we are getting good outcomes and results -- from 44-percent immunization completion to now 97-percent immunization completion, 66-percent CHDP completion now to 95-percent completion. So it can be done , I think together, if we are coordinated, if we fund the process, I think our children can have healthy lives.

Thank you.

III. Dental Health

David Perry, DDS, Pediatric Dentist, President, California Society
Wednesday, December 5, 2001 – Oakland, CA

Madam Chairman and members of the select committee, I'm Dr. David Perry, Pediatric Dentist for 30 years in the City of Alameda. I appear today on behalf of the California Society of Dentists. As President I represent over 400 Pediatric Dentists in the State of California. I thank you for the opportunity to testify on how dental health affects children's readiness and health.

I see first hand everyday the neglected epidemic of oral disease amongst the State's suffering children. This was documented in the Surgeon General report Oral Health of America, released last year. Today I'd like to show you the human dimension of this problem.

{Slides Shown}

This is a six-year-old that had severe pain, required extraction on the two baby molars, had eight teeth restored at the cost of $2,100.00. This child was able to have this work done in the dental office.

These photos show how all out rampant dental decay or caries can result in premature tooth loss. Children with Early Childhood Caries have infection, pain and suffering. If these children are hurting due to dental disease they cannot pay attention in school: they cannot eat, sleep or grow normally.

This is a five-year-old who just about had every tooth infected, every tooth in his mouth decayed. There are seven unrestorable teeth that require to be removed. The cost of the treatment was $3,400.00. There were two approaches to that: one was to do under general anesthesia in our office in Alameda. The other one would take him to Children's Hospital where the cost would be about $3,000.00 if this was done in a hospital setting.

An estimated five million school hours per year are lost because of dental-related illnesses. Each tooth loss caused by failure to care results in failure to try, impaired speech development, absences from school, the ability to concentrate in school and reduced self-esteem.

I'll take you through the steps we'll see with a child coming in with severe pain. Quite often the child has been in pain for several days, to several weeks, to several months before we see the child.

This two-year-old child has a history of seizures. Because of the history of seizures the procedures could not be done with sedation so this child was taken to the hospital under general anesthesia and restoration was performed. The lower slides show the restoration. This child has a second chance now. Actually he's lucky because he received treatment. A lot of these kids go untreated with abscess pain and constant chronic infection. In fact, out of all the things we talked today about, the most common childhood chronic disease is dental caries.

What was interesting, when Dr. Schreier was talking about that six-year-old child, several years ago that was institutionalized for killing an infant, was that child wound up in our office. He was one of the toughest kids I ever treated. He had rampant decay in addition to all his other problems.

The California Society of Pediatric Dentists has an ambitious goal of caries-free kids in California and we need your help in achieving this goal. Already I want to thank Assemblywomen Strom-Martin and Chan for helping with that because they have been a friend of pediatric dentistry and the kids.

Our first objective is to have the State provide a dental needs assessment every five years. This would provide the yardstick to measure how well we are moving towards achieving our goal of reducing caries in kids. I'm going to provide you with these two documents. The second objective is to have dental exams as a requirement for entering school. Currently the dental health foundation is collecting data in applying for a California Endowment grant to support mandatory school-entry dental examinations. We want to examine what other states have done, what changes will be needed in California law, what is the cost estimate, what impact it will have on schools and school personnel. All of these questions would have to be answered before we can proceed with this initiative.

The third objective is to overhaul the Denti-Cal system. The system is antiquated, under-funded and over-regulated. Simply fiddling with a broken system will not make it better. There are 342 pages of regulations the provider must adhere to to provide services. CSPD (California Society of Pediatric Dentists) believes that it is imperative to have CHDP (Child Health and Disability Prevention Program) adopt the periodicity schedule that supports the concept of dental referral at age one. By referring to a dentist at age one prevention can occur through risk assessment and anticipatory guidance.

It will take a huge effort on the part of the private and public sector to achieve the goals of a caries-free California. So act boldly to improve all health care of the State's most vulnerable children.

Thank you for allowing me to talk to you today.

Dr. Jared Fine
Wednesday, December 5, 2001 – Oakland, CA
In the next few minutes I want to underscore some of the salient features of dental disease and its prevalence and how that has some impact on a number of programs that we have initiated in Alameda county and I want to focus on one that I'm very excited about and I think it's addressing our weakest link and that's the zero to five-year-old population of the prevention of early childhood caries and increasing access to care. As you've heard, the Surgeon General ironically released both a report on mental health and dental health in this past year. Obviously he was right on target as far as we are concerned.

Dental disease is the most common problem that children experience. I heard someone mention the Twinkie defense today. The bugs that cause dental caries don't come with the Twinkies. Most people don't realize that it is an infectious agent -- streptococcus mutants is the source of dental caries, it's actually transmitted from person to person. Parents and caregivers who taste the food and then give it to the child are actually giving the child the infection. That's how it begins. So we have to look at it as an infectious process, a progressive process and indeed underscores the need for us to begin at the very earliest age when those teeth are at risk and they are erupting into the mouth, starting at six months of age.

Untreated dental decay is a condition of over 50-percent of California's school children, twice that of the national average. Even before a child reaches school, his or her chances of having this disease among all children is one in seven. For preschoolers in Head Start it's about twice that. For preschoolers and other children who have this infection, since the disease does not get better by itself, it will eventually spread to other teeth causing severe dental disease. In California, 21-percent of the high school students have been defined as having severe dental disease. So you can see that it is progressive. The handout that Dr. Perry mentioned, *Oral Health and Learning: When Children's Oral Health Suffers So Does Their Ability To Learn.* Copies were provided to you. It covers some very important studies indicating indeed that if school is of any value in terms of learning, distraction from school or simply absence from school is going to be a negative influence on a child's success. Studies have shown that when acute dental treatment is provide for dental problems and pain is no longer being experienced, school performance and attendance improves.

The difficulty of measuring the cost of the human dimension of this are tremendous. But indeed if we were just to look at the restorative cost you would recognize that we can't afford to be paying for the effects when we have to look at cases that wind-up needing sedation and hospitalizations. We simply do not have the resources to provide those thousands of dollars in care.

Several years ago when the Prop 99 program was identified as a vehicle of paying for treatment for problems that were identified by physicians during the well-child visit, it was clear here in Alameda County and around the rest of the state that indeed the number one problem that physicians were identifying were dental. And I think for those of you who have tracked what's happened with Healthy Families once again dental need is the underlying principal reason why families are signing up, because of the damage that has been created by un-addressed dental problems.

We're fortunate in having a semblance of programs that can begin to overcome the problem and the first one I want to mention is the Child Health and Disability Prevention Program (CHDP). For those of you who don't know, this is a well-child program that's physician driven if you will; the only entry point is through a physician's office. The CHDP exam is a tremendous opportunity for the early detection of problems and counseling and prevention that a physician might be able to provide in their office. Unfortunately the current regulations in California don't require that a child be referred to a dentist until the age of one. The federal law does not say that. That's simply a California policy that could easily be changed. The effect of that is, and this is really startling, only 22-percent of zero to five year olds in 1999 and 2000 actually got to a dental

visit under the Denti-Cal program. Considering the level of disease, that's clearly off target and factors like dentists' preference not to treat the very young, families not valuing or understanding the importance of baby teeth and physicians' belief that there are no providers of course are all contributing factors.

One stop gap measure that has emerged from the Prop 99 Program is something that we in Alameda call the Healthy Smiles Program. It's a treatment program designed to provide care for those children who have no insurance, who are identified during a CHDP assessment. Six months ago when there seemed to be money, we initiated this program and I'm happy to say that, in addition to identifying children both in the CHDP offices as well as in school and providing the initial dental treatment for them, we have also wedded to this an outreach worker. This outreach worker goes to the dental office at the first visit to help the family determine whether or not they may be eligible for insurance, of which they may not have been aware. I am very pleased to report that it looks like 27-percent of the first group have actually applied for Healthy Families, Medi-Cal or private insurance. That's certainly a step in the right direction.

The next program I want to mention is one that addresses children when they are at school. I'm very pleased with the legislation that led to Healthy Start. Unfortunately, I know that it looks like this year the funding will be frozen in terms of new grants. But in Alameda County we are blessed in having partnerships with the dental community, community health centers, in terms of going out doing assessments, screening and examinations in schools and doing preventative services on site, including dental sealants for one to two thousand kids on a resources-dependent basis and then we can refer the kids who have identified problems into on-going sources in the community and the program I just mentioned.

Now the thing that's probably been distracting you on the screen this entire time is the demonstration program that I want to emphasize. As I said I think the issue of zero to five is the weakest link in our system and the one that is the greatest challenge. Alameda County was approached by the State Medi-Cal program to apply for a federal grant that was designed to aggressively address early childhood dental caries about a year ago and of course we didn't hesitate. The goals of that program are intended to address the high level of dental caries, low access to dental care, and the high cost of dental care. The goals as you can see are increasing access, reducing the prevalence of early childhood caries and reducing the cost of dental care for these children. The target population is seven thousand children of families on Medi-Cal in Alameda County. We're very excited about this.

In order to address these goals some very important underlying issues have to be addressed and it goes back to what the nature and the progression of dental disease is. Number one: if we are really going to address primary prevention we have to do a better job of educating families about the importance of parenting practices that address good nutrition and feeding. Even well-intentioned desires to give good nutrition or palliative measures for children often lead to poor health outcomes like the proverbial Baby Bottle Tooth Decay Syndrome. So we have to recruit and we have to do good education.

The second component is training of physicians and dentists. We won't go very far in terms of this opportunity of having physicians, family practitioners, and pediatricians intervene if we

don't provide them with the educational tools and methods of counseling and even the ability to provide preventative interventions like fluoride varnish but that in fact is indeed what we intend to do. This by the way is being piloted in Washington State and it's being done successfully. So we intend to have physicians go through continuing education training so that they will have the tools with which to address the problem on a preventative basis as well as detecting problems that have already developed.

Similarly with dentists: dentists by and large are not pediatric dentists. Many dentists are not willing to see young children -- it's difficult their training doesn't necessarily include that to a large extent. So we will be engaging dentists in the latest management techniques and all the new preventive therapies that have been generally accepted to improve the likelihood of reducing the incidents, the prevalence and severity of early childhood caries. Now those are the clients, dentists, and physicians but what about the system. The system that mediates that relationship, in this case, is enhanced fees. We intend to augment the fees for dentists and physicians with the help of the State in terms of the Medi-Cal reimbursement and Alameda County is going to match those funds so that for those things that physicians were not doing before that are dental services they will now be paid and for those dentists that are enrolled in the Medi-Cal Program; they will get augmented fees from providing services and new fees for services that were not covered under the Medi-Cal scope of benefits.

This is very exciting. It's about paying adequately for the things that we think are important for prevention. Obviously our partnership with UC San Francisco has largely got to do with evaluation, which is an important aspect. We want to show that this four-year demonstration project is actually making a difference so that the successful parts of it can be institutionalized.

I want to point out that no program that's a demonstration program, that could ever hope to get off the ground of this magnitude could possibly be done without a significant number of partners. The Child Health and Disability Prevention Program, which isn't mentioned there, has already added staff to help us with this program. You know they are dedicated to improving access to care. Obviously the state, I mentioned the Alameda County Health Care Services Agency, UC San Francisco, Delta Dental, the three dental societies, California Society of Pediatric Dentistry (CSPD), the Academy of Pediatrics. We are going to be working very heavily with the Head Start program, with the WIC programs, the Prevention Research Center and others.

I'd just like to mention a few possible policy recommendations to take forward in terms of all of these programs that I've described. And I'm very pleased to hear Dr. Perry's comments and the leadership that CSPD is providing on the one-year-old automatic referral and also the school entry requirement of having a dental examination. Certainly those are two on the top of my list. In bad economic times it certainly possible for those services under Medicaid that are not required to go on the potential chopping block, like adult dental. I just want to make a comment: I've seen past administrations try that and I certainly would hope that we can maintain an adequate level of the reimbursement for dental services for children, even though things might be tough over the next couple of years. Secondly, there needs to be some clarification of the Medical Practice Act so that there is no question whether physicians can apply fluoride or do any of the other preventive interventions that might be designed by the demonstration project. As was mentioned earlier I think we need to adopt some standards for child care settings, licensed

child care centers in terms of, like with Head Start and Early Head Start, the requirement that children have an evaluation as early as possible so they don't slip through the cracks.
The CHDP program is wonderful but it is unfortunately limited in that dentists are not really part of that system. A policy change in California might make CHDP include dentists. So dentists become partial providers of CHDP services. This is actually in the federal language but California has decided to separate it and I think that weakens the multiple entries points into a well child system significantly. Especially as kids get older they tend to go less to the physician and more to the dentist but indeed need to go back to the physician for evaluations.

Finally, most of the data that I've been reporting is eight and nine years old. California is out of compliance with the requirement that we evaluate the oral health as well as mental health and many other key health conditions on a regular basis, as under the federal guidance to Maternal and Child Health. I would encourage that we push that issue, so that whether it's on a local level or a statewide level we have a regular assessment of oral health needs of California's children.

Thank you.

IV. Improving Access to Health Care and Coverage

Dr. Neal Kaufman, Director, Division of Academic Primary Care Pediatrics, Cedars-Sinai Medical Center. Vice Chair Los Angeles County Children and Families First - Prop 10 Commission
Thursday, November 8, 2001 – Culver City, CA

I'm speaking on my own behalf, not on behalf of the commission, because the things that I'm going to be speaking about the LA County Prop.10 Commission has not decided upon and I need to publicly acknowledge the fact that we are a public process who will make decisions. So these are my own thoughts.

What I'm going to try to do is talk about what it takes to grow healthy children, what are the roles for health care providers in that endeavor and how should they be linked to the community, what are the ways to improve the quality of health care, and finally some suggestions on what are some of the next steps. Most of my remarks are summarized in the handout that you may have in front of you.

The first thing to think about from my perspective is what does it take for children to thrive? We know that children need to be born healthy and wanted, and that if you're not born healthy and wanted then you have a much worse chance of succeeding. That they need to have nurturing, safe, and stimulating homes and communities. I use each one of these words critically: nurturing, safe, and stimulating. They need to have an adequate family standard of living. That we know poverty is a major predictor of poor outcomes for children, though obviously most people in poverty do very, very well, it's much more difficult. You need to have access to a range of services that are listed on the handout, as well as a strong societal commitment to the well-being of children, as evidenced by the three people and others here, and the others behind them. And if we think about children when they're born, they're basically on a trajectory to the

rest of their lives. And the problem is, that a very tiny perturbation, or change in that trajectory, can have lifelong consequences. And so for example, if a family grows up, the child grows up in a community or in a family with substance abuse, inadequate health services, family discord, maternal or paternal depression, those things could all push the trajectory off course. If there instead you see parent education, emotional support, that the child is read to, that there's appropriate discipline, if they're in an enriched learning environment, if they have proper nutrition, all of those things may push a child's trajectory back up towards the place where they should be going.

The problem is that we need to be thinking about each of those possible things that push you off the trajectory and make sure that the services and systems we provide keep them on the trajectory. If you think about the problem, the scope of the problem, about 60 or 70-percent of children are doing okay. That means 30-40-percent are not. The vast majority of the services that we've used in the past or thought about really address the two to four-percent of children who have major, obvious problems -- congenital abnormalities, serious medical conditions, profound developmental delay. That's a very small proportion, we need to be addressing those, but we really need to be developing systems that recognize that about 10-15-percent of children have special health care needs, that maybe 20 or 30 or 40-percent have special behavioral, developmental, or learning needs. And that if we don't have systems that address the entire range of problems that kids have, we'll be focusing only on those children who are most obviously in need.

And if we think about the purpose of I think today's discussion, it is to really think about how does the delivery of health care fit into the whole process of helping children be ready to learn when they're five, or be able to succeed later in life. So what I want to do is just give you, some of my perspectives on child health services, and why there are some good parts and some not so good parts in terms of partnering child health services with other activities.

So for example, health services are accepted and trusted by most parents. Children are seen very often throughout the first years of life, and perhaps the only place that a child may be seen by a system, and that may not even be in an organized setting, is medical care. We're also widely distributed -- there's offices everywhere, they're close to families, we have existing funding streams. We'll talk later about some of the problems with those funding streams, but it is funding -- perhaps not adequate, or definitely not adequate -- but it is funded. And we do have the capacity to enhance those services, I wouldn't say it's a certainty, but we certainly have the capacity.

On the other hand, many children have limited access to services. The essentials in the services that they need are often not included. The basic benefit package does not really meet their needs. Also, particularly in the area of developmental, behavioral, and mental health services -- they're not emphasized, physicians aren't well-trained -- the services might not be available. And to me what's also very important is that many times those services are not linked to the providers of care in the community.

And so for me, the way to think about this, is to say we need to conceptualize a framework of three overlapping, I guess I'll use the word, systems. That we need to strengthen each of those,

and particularly strengthen the linkages. I'll call one, Child Health Homes; the second, Community Nests of Support; and the third, Centers for Education and Quality. Let me go briefly over each one of these.

Child Health Homes -- a.k.a. medical homes, are basically a site where each child has an identified entity, an identified individual in sight, who takes responsibility for working with the family in the community to meet that child's health needs. They provide primary care with a full range of services, they address children's special healthcare needs, they provide developmental/behavioral services, they function ideally as hubs of health developmental connectivity. With linkages to community nests of support, they use information technology appropriately to get information to the families in the way that the families want to learn it. They're committed to continuous quality improvement and they're linked to what I call Centers for Education and Quality.

So those become a whole new way of providing pediatric or child health care, that would, I think, better meet the needs of children. They need to be involved with Community Nests of Support. First, you have to have strong communities, you have to have competent parents, you have to have effective organizations and associations. That's a given.

But what I mean by Nests of Support, imagine thinking of it in a few different ways. One could be by age. You might say we have a nest of prenatal to one. We have expecting parents and infants who often have similar kinds of needs. We have children about one to five, a preschool child. And we have children in school -- five to eighteen. We might also think of the venues where these Nests of Support may occur. Community based organizations, home, private sector agencies, schools, neighborhoods -- a whole array of programs. And the content of these programs are quite varied ranging from nutrition, early learning, family support, family literacy, early intervention. But if we think of those nests of support, we need to strengthen those nests and make sure they're linked to the child health homes.

One of the problems, as a practicing pediatrician trying to train physicians in the future workforce, both physicians and others, is that we don't do a very good job, particularly in training physicians to meet developmental, behavioral, and mental health needs of children and families.

So I think we need to conceptualize the Centers for Education and Quality. Those are places where training occurs of physicians, nurses, social workers, mental health professionals, dieticians, nutritionists, etc. And they provide primary care, they provide specialty care, they provide education to a range of individuals, they provide research into a number of different areas, but most importantly they need to be linked to Community Nests of Support and to Child Health Homes. The idea is to pull the system together and link those three areas.

So what I want to do is very briefly summarize some examples of ways to approach this that looks at improving quality, redesigning practice, improving connectivity, and improving accountability. So within developing change concepts, there's a number of different strategies that look at how do you take innovations that have been shown to work in small areas and allow those innovations to diffuse into multiple settings.

There's a group called the National Institute for Child Health Quality. It's part of the Institute for Health Care Improvement, involved with the creation of a number of improvement efforts around health care throughout the country. And they're involved right now in looking at how do you particularly improve developmental services. There's also one improving the health care of children in foster care. And if you look on the handout, I've listed, I guess eight or nine, different kinds of things that a practice would do to try to improve the developmental services including obviously talking with the family, agreeing on guidelines, identifying children at various risk, or problems stratifying the care, using prompting systems for staff and patients, using structured assessment tools that contain historical information and observational information, and figure out a way to simplify the referral process. These are all very important issues that we can do and use to try to improve the quality or to change the way pediatric care is given.

A specific example amongst many, and this one's been studied and it's now in about thirty or forty communities in practice around the country, is called Healthy Steps. Healthy Steps was started in Boston and has now been pretty well-researched to show it works. And basically what they do is go into a pediatric practice that's willing and interested, identify a new person for that office, they call them developmental specialists, they're specifically trained in helping physicians and families meet developmental and behavioral needs of the children, they provide special enhanced office visits, specialized home visits, they have written information that they hand out to the families, they may have group sessions, and they do periodic developmental screening and family health assessment. Because pediatricians you can either say politely, are too busy, or you could say less politely, are not competent in meeting all of these needs, take your pick, by having people who have these extra expertise in the office, it really transforms the practice.

The problem, however, is that even in the practices that do this well, getting a child to a definitive treatment service for a developmental/behavioral problem is nearly impossible, even when those services exist, the linkages are terrible. Connecticut set up a program called Child Serve. If a pediatrician in Connecticut, started out in Hartford and now they've moved statewide, identifies a child who has a problem, in this case it's a behavioral/developmental problem, they call Child Serve, 1-800-Child-Serve, tell them about the child and the problem -- with the parents permission, obviously -- and that system makes sure it happens. As an aside, it takes them an average of fifteen phone calls to make that referral, to the simple thing that should just happen. This is complicated stuff, they become experts at it.

Another example is a program called FACCT's, which is a national quality assurance program, which has looked at using measures to assess a health plan or provider on a range of different activities that promote healthy development -- whether the offices are using anticipatory guidance, giving health information properly, etc. -- they're listed there.

What I wanted to do is give you some examples of links to nests of support that maybe some of you have been involved with, actually some in this audience are participating in it, that show the kinds of things that we can do if you get practices to link to nests of support, or academic medical centers, or centers of quality and education.

California Hospital Medical Center and the Hope Street Family Center I think will be featured, and we'll discuss it today. They basically are a birthing hospital that has child health care, as well as early learning programs, family support, and family literacy. That's a way to take the place where people come for what they think is medical care -- prenatal care, child health care -- and linking them, providing some of the services on-site, and then linking them with community services.

Another program that many of you may not be aware of is the American Academy of Pediatrics has a program called Healthy Child Care America. It started out in North Carolina and is now national. Each one of the fifty states has a program that tries to identify pediatricians who are interested in working with child care agencies and has a training program and curriculum and materials to help that physician to link to a child care agency to look at the health and safety of children in child care. Again, it is a linkage between a child health home and a community based nest of support.

And another example is one that we've created at Cedar-Sinai with the LAUSD, John DiCecco, et.al. Basically we have four LAUSD elementary schools and we have a multi-disciplinary, bilingual team at the site. They basically ask three simple questions, which are very difficult to find solutions to. The first is does the child have health insurance. (Medi-Cal, Healthy Families, California Kids, etc.) The second is do they have a doctor. The third is do they have an unmet health need. If we get the wrong answer, our goal is to try to solve it. The answer comes from a Center of Education and Quality, and academic medical center linked to a community-based Nest of Support -- the schools.

So the question is: what are the next steps? If you take this model, that says we really need to think about how do you strengthen Child Health Homes, how do you strengthen Community Nests of Support, how do you strengthen Centers of Education and Quality, and most importantly, how do you strengthen the linkages?

The first is to create consensus on the priorities and approach. We need to all agree on a broad definition of health, recognize that multi-disciplinary approaches are important, use evidence-based approaches, integrate the services, and as our Assemblymembers suggested, create the political will to make it happen.

We need to create an early-child development infrastructure, which includes strengthening communities, facilitating systems changes in the new understanding of how to change systems by micro-evolutions that allow creative solutions to come out of the wisdom and experience of individuals. We need to encourage those creative approaches, and obviously provide some resources, though I will argue we can do some things for no cost and low cost in this new environment.

We need to provide a seamless system of support, and basically do the things I was describing on those three different areas. We need to assure access to quality health care. We need to streamline and simplify enrollment. It is atrocious, even though it's gotten better, it's not sensible.

I think we need to consolidate a number of programs that exist at the state level. Medi-Cal, CHDP, Healthy Families, perhaps CCS *(California Children's Services)*. I don't think that the way it's set up now works, I would have predicted it wouldn't, and unfortunately, I think I'm right.

We need to improve participation and retention, both by providers as well as by families. We have children coming in, going out, they stay for a short while, they then lose eligibility, we don't keep them in the system, they're voting with they're feet -- they're finding that the programs don't work. And obviously we have to assure an adequate benefit package, or an appropriate benefit package for all kids.

We think specifically on the quality of services. I think we need to make sure that developmental and behavioral services are covered in plan contracts. We do have the ability to look at the plans, to look at their contracts, and to be sure that they cover brain development, as well as developmental and behavioral services.

We need to hold them accountable. We do that by identifying the kinds of outcomes we want to see that relate specifically not only to immunizations or to other things that HEDIS might look at, but really particularly to look at behavioral, developmental, and mental health issues. There are quality measures that exist for that, we need to focus on that, we need to measure those activities, we need to provide incentive for improvement. And those improvements need to be at the provider level, at the practice level, and at the system level. Unfortunately, if we approach only one of those three levels, and not all three, we probably aren't going to have sustainable changes.

So what I've briefly tried to do, and I hope I didn't take too much time, is to say that we need to really think about how do we create these activities. I think we need to monitor what we're doing, we need to collect some data to see if it's working, we need to report that data publicly to consumers, to families, to communities, to providers, to policymakers. And if we do that, and we think about integrating Child Health Homes, Centers for Education and Quality, and Community Nests of Support, and figure out ways to support each of those three areas, I think we'll go a long way to improving the health of kids and preparing them for school.

Thank you.

Question and Answer Period
Assemblymember: I had a couple of short questions. When you're talking about a seamless system of early childhood development, I'm looking at page four, explain just a little bit more about the child health homes.

Dr. Kaufman: The child health homes, some people use the term medical home, but it basically says that children and families need to have access to a place that they know that if they had a problem, that place would take responsibility to work with that family to help solve it. So for example, if in my office I see a child who has speech delay, that I know that it's my responsibility to identify that speech delay, to talk with the family about ways to prevent it, ways

to do more investigation -- get a hearing test, or a speech therapist consultation -- and then to be sure that it happens. A philosophic responsibility…

Assemblymember: So it's not a location? It's a concept?

Dr. Kaufman:
Well, it's both a location and a concept. If you talk to the pediatricians in the audience, they would say that the physician's office is a medical home. I would say it a little differently, and say that it is a concept that needs to have a location, rather than a location with a concept. By that I mean if you only think of it as a medical home, where a child can make sure that his heart or kidneys or lungs are taken care of, it doesn't have a broad enough issue. So if you take, the health home and connect it to the community nest of support -- the places where those services happen -- it's naïve I think and unrealistic to think that the physician's office will be able to provide most of the services a child needs -- particularly developmental, behavioral, and mental health issues. We do very well in bio-medical and physical issues. We need to connect to that, and that's what makes it a health home, rather than just a medical office.

Assemblymember: Alright. So it's saying it's the connectivity part, and it's also a training part for physicians, isn't it?

Dr. Kaufman: Well, it's first a values change. It basically says this is what we have as a value and expectation for the physician, it's training on how to better identify those particular issues -- whether it's domestic violence, child abuse, etc. -- and it's identifying ways to link what has now been found to the person, entity, organization that can make a difference. And it's having that organization having the capacity to take that referral. So it's really the range of those.

Assemblymember: Okay. The other question I had had to do with access. You talked about streamlining and simplifying enrollment. Would you comment on the changes that the Legislature and the Governor just signed that allow us to use Title I information…

Dr. Kaufman: I'm not an expert on that, so I can't tell you…

Assemblymember: Finally, you said consolidate Medi-Cal, CHDP, Healthy Families. Because they have different funding streams, people have thought that's not a good idea, but on the other hand, it could be. Could you talk just a little bit more about how one might actually do consolidation of all of those?

Dr. Kaufman: This is a very complicated process and I don't pretend to have a magic bullet for it. I guess the reason I put it here is I think it is the conversation we should be having. Conceptually, if you look at Healthy Families and Medi-Cal, let's take them first, CHDP second, it's basically the same program. They're insurance programs for people who fit in a particular income level. And unfortunately right now they have entirely separate programs. You may go back and forth between one and another, you may have one child in one family on one, another child on another. As a clinician, I had to set up an entirely separate system for those children who are Healthy Families insurance versus Medi-Cal insurance, I have to have a different formulary, a different referral network, a different approval process. The whole implementation

side of the programs becomes extraordinary complicated for the clinician end, and for the family I think it becomes complicated, even if the forms themselves have been streamlined and made easier. So I was always of the opinion we should have taken the option to expand Medi-Cal eligibility to a higher level rather than setting up a separate program.

V. Mental Health

Marleen Wong, Director, LAUSD Mental Health Services
Thursday, November 8, 2001 – Culver City, CA

Thank you. Good morning, Ms. Chan, Ms. Goldberg, Mr. Lowenthall. Thank you for the kind invitation to be here today.

Let me start from a national perspective with the U.S. Surgeon General's first report on mental health that was published in December of 1999. The significance of this was the U.S. Surgeon General's Office was established in the 1800's, and this is the first national report ever published on behalf of the U.S. Surgeon General's Office, a comprehensive report from zero to adulthood and geriatric issues in addition.

What the U.S. Surgeon General did was a massive effort of looking at all epidemiological studies from rural, urban, and suburban areas and coming to the conservative conclusion that during the course of one year, 20-percent of any given child population has a mental health disorder serious enough to require professional intervention.

Only three to five-percent of those children have a condition that is severely disabling, such as childhood autism or schizophrenia. We find that there are really two areas as we look at the trajectory of development. Over a period of a time, the World Health Organization looked at all the developed nations and factoring all health conditions, including mental health, found that depression is the number one disabling condition in the world. I think what they also found was that the question occurred: what happens to children who are depressed? We are learning more and more that it's biologically based, it's not just a matter of stressful life environments or development. That depressed children who are not treated become depressed adults. Seventy-percent have a recurrence by the time that they are adults.

Beginning with these basic facts, and they're really very limited facts, the bad news about mental health treatments and what we know about mental health, is that the information about childhood disorders is quite small. All of the evaluations, effective practices, treatments, including the psycho-pharmacological treatments, are geared towards adults. There are just now beginnings of research around the childhood disorders.

So we do have a few programs that I think point the way for the future. And I guess I'm here to talk about, a little bit about, school readiness. One of the statewide, wonderful programs is Early Mental Health Initiative. In Los Angeles, we have over thirty sites which have Early Mental Health Initiative programs and as you know, it's in the early grades providing a one-to-one interaction with an education-level aide for children who are having difficulty interacting in the classroom.

I think if you look at that statewide, you'll find that the pyramid where they talk about children -- most children -- being ready for school, in urban areas and especially in poverty areas, that pyramid is inverted. We actually have more children who are not ready for school, don't have the skills to interact with an adult, to establish peer relationships, to follow directions, to understand where to focus. I mean these are not issues of mental illness, they're issues of development.

And we need more programs that are not based on competitive grants, which the Early Mental Health Initiative is based on, it's a competitive grant. That needs, I think, to be generalized. As we have in our district of the early childhood programs, you may know as I move into early childhood/education division hearing in Los Angeles, we have 101 sites of children centers. Approximately 103 families are enrolled per site. There are about 80 preschool programs that are embedded in the children centers. And it serves a total of about 13,700 children.

Well the good news is that 13,000 children are served, but when you look at a population in Los Angeles County of many, many more hundreds of thousands of children, they are unserved. And those are programs in which early intervention, preschool age support and assistance -- to really enhance and support development -- can play such a determining role.

If there were funding, in fact, to support quality day care, early education, appropriate screening, mental health services in schools, I think what we know today about brain development -- that early education is not just helpful and enriching -- it's absolutely essential.

I want to speak about one last thing, and that is my work in New York after September 11th. I was actually called the day after by the Chancellor's Office of the US Department of Education, Council of Great City Schools, and in their kindness they wanted to send a military transport and strap me to the side of a plane, and I decided to wait until the planes started flying again.

But since then, having been there at Ground Zero, and with the police, with the Chancellor's Office staff, etc., and as you know, seven schools were at Ground Zero and 8,500 children had to run for their lives in that evacuation. What they saw changed them forever. They witnessed mutilating injuries, they witnessed dozens of people jumping from the buildings, the collapse of the buildings and the towers, and the fact that as they were running, they were running past steel girders and pieces of people and things were just embedding themselves in the buildings around them.

And there are a lot of lessons to be learned from New York City. First of all, that decentralization can go too far, when you have forty superintendents and you try to implement a disaster-related program. That when there is no system of care in schools, because of terrible cuts, draconian cuts, that even the good will of people cannot overcome the issues of a bureaucracy that has no policies and procedures, and no staffing to implement the changes.

That when there is no communication, and you have to begin on day one, the existing turf issues overwhelm the intent of the individuals to make some change. And that charitable organizations cannot meet the needs, regardless of whatever their intentions are, to either addressing immediate

or long-term needs. That these kinds of programs have to be encoded in legislation or formal policy and procedures, and there have to be dependable funding sources.

I think the real lesson that we have learned *(from 9/11)* is that while the country's attention is focused on these young people who have now been traumatized and changed forever, I don't think it's too much to say that we have children in our urban centers who are terrorized all the time by violence, either in their homes or in their communities. We really do need to implement programs for exposure to trauma.

There are two things that we know about children's health -- one, there are effective interventions for both trauma exposure, violence exposure, and depression; and two, children are traumatized every day. We did a small study with the Rand Corporation, and we found that out of 1,000 sampled children, 40-percent had been exposed to life-threatening violence. They had more negative comments in their cumulative records, they had lower GPA's, and they had more absences from school.

These are the children I think every day here in our city that are everywhere present, they are hidden in plain sight, and hopefully, New York is the wrong way to the right place, which is how do we bring very much needed services to these children and families.

Thank you very much.

Dr. Lynne Huffman, Department of Pediatrics, Stanford University
Wednesday, December 5, 2001 - Oakland, CA

Good morning, thank you for the opportunity to be here. I brought a set of slides and have reproductions for you. We're shifting our perspectives somewhat to focus more specifically on mental health issues and how these issues relate to children's readiness for school. I noticed in our discussion so far, this morning that actually there are at least two pieces on being ready for school that each of the panelist have eluded to: one is the daily being ready and so when you get up in the morning are you ready to get to school and engage in your classes. Another piece is being ready at school entries, so that process and Rene eluded to this, the first five years of life and then being ready to launch into your careers as a student.

I just want to highlight, although I realize this is part of a series of hearings, why it is that we are so focused on this issue and certainly the Assemblywoman acknowledged academic success is a paramount reason in focusing on readiness for school. But there are other consequences to not being ready, that are equally as important and I wanted to raise these in our thinking today. Academic failure is very important, being labeled as a delayed learner, school tracking program so within class ability grouping, being retained in grade, being pulled out for special education, or actually special education classes. So a child who is not ready for school is at greater risk, for each of these experiences. Decreased likelihood of positive social exchange and peer support, lowered self-esteem, decreased motivation. So you can see how all these things build upon each other and can have profoundly negative consequences for kids. Looking farther down the road, lowered expectation of parents and teachers, so as kids are not successful and begin to fail, the expectations of the adults around them shift. Later problems with emotional academic and social

development, ultimately at greater risk for school drop out, repeat adolescent pregnancies, this is a risk factor for that and then larger problems with disruptive, delinquent and anti-social behavior. So profound consequences of not being ready. This does not happen for every child, but it puts a child at greater risk for these issues. Because I only have ten minutes I want to say there are three things I want to address, and they are from the perspective of a behavior developmental pediatrician that's my specialty training within the context of general pediatrics. I want to bring attention to the ways a general pediatrician can be involved in promoting school readiness, being aware of risk factors for problems at the time of school entry, I want to speak briefly about that -- early detection. We had some discussion on screening but I'm 'going to focus on mental health issues, and early intervention, I want to speak on a program we're engaged in at Stanford in this arena.

So to focus first on risk factors for problems at school entry, how, as a general pediatrician, would you know that a child is at risk for having difficulty as they begin school? We recently completed a very comprehensive review of the scientific literature that looks at what we actually know about risk. It is interesting that many of our Federal policies and State policies are designed and implemented based on a sense of our understanding of risk but in fact the scientific literature that supports that varies. So this review of literature was important to me at least to complete. We did this review looking at 15 years of literature, included original research only, not commentaries or review articles and found that there are at least 32 identified risk factors that put kids at risk for having problems with school entry. These risk factors exist at various levels, at the individual level, at the level of families, and peer relationships, risk factor in the neighborhood and community, and social cultural levels. In our conclusion based on this review, given all of our concerns about risk, they are relatively few large studies that have been investigated that include attention to both the physical and mental health factors that are associated with school readiness and early school failure.

Now, having acknowledged that there is a substantial degree of research that supports our belief that there are some clear risk factors for problems and we've heard some discussion about that this morning. Low birth weight, the children who are born small for their gestational age, or who are born pre-term, are at risk for problems, low IQ clearly, low socioeconomic status, and this is frequently put out as a risk factor. Now what is it about socioeconomic status? Well, this is where research really needs to be done, sort of taking apart what's conveyed by your socioeconomic status in the community, is it a marker of low family income specifically, food and resources inefficiency or lack of parental education? We don't know but it's important to get down to that level, in order to plan our interventions. And, then I have highlighted early behavior and peer relationship problems and that gets to the point of this panel.

So what's the role of the general pediatrician in terms of detecting childhood mental health problems? We know there's a high problem of psychosocial behavioral problems with kids. Ten – fifteen-percent of kids have significant behavioral problems as they present to a pediatrician's office. Some groups are at particularly high risks so remembering what we just learned about risk factors. But the vast majority are undiagnosed by pediatricians and there are many barriers to early detection. What are these barriers? Why is it so difficult given the high incidences of problems for pediatricians to pick these things up? We heard a little about this already. The pediatrician-family interaction, although frequent as Rene described, is brief. So you have a ten

to fifteen minute visit, the pediatrician needs to get done what they want to get done, the parent wants to have an opportunity to say what they want to say, the child needs to be examined, and it's a very short amount of time to pick up these important problems. Insufficient pediatrician training for identifying behavioral problems and I won't go into that further. I think we all agree that this is something that needs additional resources and attention.

The infrequent use of practical screening tools, I highlighted this because I think this is something we could begin to incorporate into general pediatric care that would assist the pediatrician in identifying problems. And then the under-referral of mental health problems once they're suspected, what do we do about it? Why is it that if they are identified frequently the identification stops right there. There may be parental reluctance to discuss behavioral emotional concerns, limited perception of the need for mental health services on the part of the parent, few links to community resources, and limited insurance coverage. So I just want to propose that there is at least one appropriate screening tool that would be used in a general pediatric environment that would help to identify children who may have mental health problems. This is the pediatric symptom checklist. It's been very well studied in a large number of pediatric offices across a variety of groups of children and a large range of kids and it appears to be a check-list that has reasonable power in terms of appropriately identifying children who need to be followed more closely.

The last of the three points, how can general pediatricians be involved in intervening to promote school readiness. I just want to bring your attention to a program called 'Reach Out and Read'. Packard Children's Hospital at Stanford is utilizing this program and it's the involvement of the pediatrician in promoting emergent literacy in children and their families. And at every well-child visit a free book is given to the child by the pediatrician, a prescription to read. So really promoting the idea of reading is given to the parent, there's modeling of reading in the waiting room by volunteer readers and the results of the program both locally at Stanford and nationally show not only increased book sharing, an increase in receptive and expressible vocabulary but increases in positive interaction between the child and parent. If you think back to one of those risk factors of relationships, problematic relationships, our belief that this may be a small way of decreasing that risk. So just to reiterate these three areas: education, increasing primary care provider's understanding of how mental health problems put children at risk for problems at school entry; identification**,** implementing the use of screening tools within federally and state supported health clinics in order to ascertain behavioral mental health problems early; and then intervention. I would support the inclusion of primary care based emergent literacy programs as a way influencing school readiness as well as positive interactions between children and their parents.

Thank you.

VI. Early Childhood Assessments

Dr. Rene Wachtel, Director, Child Developmental & Behavioral Pediatrics, Children's Hospital Oakland
Wednesday, December 5, 2001 - Oakland, CA

Good morning my name is Dr. Rene Wachtel, I am the Development Pediatrician and Director of Developmental and Behavioral Pediatrics here at Children's Hospital. What I'm going to focus on is issues of assessment as it relates to children's readiness and health, because when we want children to be ready to learn for school we have a number of issues, related to health and developmental assessment that need to be addressed . I'd like to focus on that in particular. Other members of the panel will be talking -- Dr. Crain will be talking about the screening on the general pediatric, the care of children on an ongoing basis and Dr. Herb Schreier will be talking about some of the issues related to neuro-psychological assessment. What I'm going to try to do is paint a broader picture of the assessment component.

First of all I'd like to clarify what we mean by assessment that really has a number of components including a comprehensive history and a collection of relevant information from a variety of sources including preschool and daycare. We're talking about comprehensive clinical evaluation including the administration of appropriate test determination of a child's diagnostics, determination of strength and needs and treatment planning. So it's really a comprehensive process and there may be just components of it that are triggered or maybe the whole process that is triggered depending upon what the needs are.

I just want to mention very quickly here at Children's Hospital, we have a number of programs that provide developmental assessment. We have both a child development center that serves children birth to age 18 and a specialize group of child early intervention services that serves children zero to three. Briefly within these different programs we have a child development clinic, a communication disorder clinic, a psychopharmacology clinic, that we run conjointly with child psychiatry, a nerve developmental medics clinic, an ADHD *(Attention Deficit Hyperactivity Disorder)* clinic, and a follow-up clinic for children with neo-natal intensive care unit stays and these are directed toward children for a variety of ages within that. We also believe very strongly in prevention in early intervention and have together with the Alameda County Every Child Counts Commission, a new program called Special Start that together with the public health nurses does home visiting for children who are at biological or psycho-social risk. We have a medically vulnerable home visiting program, we have a parent-infant program together with the Regional Center of the East Bay for children that have developmental delays, birth to three or at high risk, we have TGIF programs for children who are foster care vulnerable, we have a leap program for children zero to three who have low incidents and we have a developmental program within the neo-natal intensive care unit, again to do prevention with early intervention.

How does the developmental assessment process work? The first thing is a referral that means that somebody has to identify that there is a potential problem. And, that may come from the primary care physician, and Dr. Crain will be talking about that, it may come from the parent, it may come from another concerned party, it could be the social worker, in a foster care unit it could be a regional center case manager, it could be a public health nurse, it could be a teacher.

There then needs to be some kind of initial review to determine what the most appropriate program would be.

From my perspective a comprehensive developmental assessment is generally best done by an inter-disciplinary team that really has sufficient time to review both the previous information that has been gathered; that can obtain a full history focusing on both the child and family; that has appropriate supports, for example translations services if needed; and that then performs a direct clinical observation of the child that will be ideally in several different setting or interactions that uses appropriate disciplines, appropriate tasks and clinical tools and really assess all the areas of a child's function. Including physical health, including hearing and vision, psychological function, including cognitive abilities, adaptive abilities, emotional behavioral. And you'll be hearing more of that later, speech and language, gross and fine motor, academic and pre-academic skills . So we're really talking about something that really should be very comprehensive if were going to have children who are attending school in their best possible mode for learning.

Why is it important to have this part of the component to determine the diagnostic? I feel really strongly about it for several reasons, one of which is it determines further medical testing that is necessary, for example: determining that a child has mental retardation is very important for a lot of reasons, one is to determine the etiology, which may include genetic testing. Second it provides information to families about what the treatment needs of the child are and that can be across programs, across systems, as well as across different disciplines. It maybe future medical needs of the child and it really gives the family some answers to their questions about what is going to happen with my child. Without knowing the problem it is very hard to answer that question. Lastly it allows access to specialized programs, for example the Regional Center System, California children services, Supplemental Social Security, specialized school services, etc. Assessment is not just about diagnostics, it also is about looking at the child's strengths and needs in each of the child's developmental domains and looking at what are the treatment services that might be needed, in order to address those areas of weakness and how to do it in a comprehensive way. It also serves as a baseline for looking at how treatment is helping so then it can be modified.

I'd like to spend my last couple of minutes talking about what some of the issues are related to developmental assessment and what I would suggest as possible approaches. One major issue in Northern California is insufficient numbers of appropriately trained pediatric providers. There really are very few, developmental behavioral pediatricians, child psychiatrist, and speech pathologist who are trained in pediatrics and occupational physical therapy. There really is a tremendous need.

What are some of the possible solutions? I think we need to develop additional training programs. For example, one collaboration that has led us to be able to provide more training is that Children's Hospital has partnered with the Regional Center of the East Bay to develop a fellowship program in Developmental Behavioral Pediatrics to try to address some of those needs both for the Regional Center and the community. I think it will be very useful to investigate the possibility of developing a Northern California University affiliated program to facilitate this disciplinary training. There are a number of colleges and universities in Northern

California that train people in speech pathology and occupational therapy, etc. But there is no collaboration or coordination, there's no identification of the needs in inter-disciplinary training; in highlighting the need for pediatrics in particular, and in enticing people who are going into an occupation physical therapy training program, that pediatrics is an important area of need. Another issue is that many systems do not accept evaluations that are performed by other programs. So we wind up spending a lot of insufficient resources doing over again and over again, something that has already been done. This wastes time and personnel and certainly has a lot of negative implications for the family, who is already very stressed by this whole ordeal.

What are some of the possible solutions? From my perspective one is setting up a state task force of relative agencies and stakeholders to really look at what are the best practices that we ought to be using for assessment and then how could we have agencies sign on to these. So that if people meet these standards then, in fact, we would accept cross-agency evaluations, thereby eliminating the need to have to repeat evaluations and thus just go forward as far as implementing treatment.

Another set of issues, which we can probably spend a whole day on, are significant health insurance barriers to providing comprehensive developmental health assessments. For example, many insurers do not cover developmental problems. They're just out. A second is that many insurers do not cover specific components of development assessment. For example, speech therapy may be just out, or it may be as with Medi-Cal that doesn't cover speech therapy evaluations and services after the age of three. Then the whole issue of managed care and how care is now divided in this symmatic and mental health care system and each system saying "Oh it's not my responsibility it's the others" and we have a lot of conflicts and problems trying to get children the services that they need. So, one possible solution that I would suggest would be a joint project together with the Department of Managed Health Care to determine what changes might be necessary to enable children to access needed services without so many barriers.

So in conclusion, I would like to suggest that comprehensive evaluation is needed in order to provide appropriate treatment and to provide access into many good programs that exist in California that we are not appropriately using. Barriers exist including insufficient personnel, insurance barriers, and to me this is an area of great importance in the promotion of children's school readiness and school success. I'd like to thank you for the opportunity.

VII. Nutrition

Eloise Jenks, Public Health Foundation,
Women, Infants, and Children (WIC) Program:
Thursday, November 8, 2001 – Culver City, CA

I'm Eloise Jenks with the Public Health Foundation Enterprises WIC program. And I think Deborah mentioned that her program is one of the secret programs. Sometimes I think that WIC is one of the secret programs, even though WIC is a very large program, and in fact, throughout the State, has the second highest level of funding within the Department of Health Services after Medi-Cal.

So within WIC itself is a special supplemental nutrition program for low-income mothers during their pregnancy and then we see the child up to the age of five. One of the things I wanted to comment about is that in WIC we see so many children. We see the children under 185-percent of poverty. And we see about one million families a month within WIC throughout the State.

Now the thing that's so interesting is that most of our families are minorities, they are low-income by definition, they have nutrition issues or they wouldn't be qualified for WIC, so we have food security issues, hunger issues, things like breast-feeding. And I wanted to comment about breast-feeding which I didn't hear from Wendy. Breast-feeding is a learned experience by every mother and you can't just assume because that lady over there knows how to do it that the next lady knows how to do it. So it's a learned experience that takes time, process, and so forth.

We had a lady in our office yesterday who came in for some breast-feeding support, with a 12-day-old baby, she is expressing some milk, but somehow or another the baby got used to the bottle, she didn't know how to get the baby on the breast and she wanted to breast feed. This is a learned, hands-on, somebody help me, I need help. And to be successful they need that kind of help.

WIC is out there in the community. Within our agency, we have 50 centers within Los Angeles County. We have centers, we're in the community, we do health education, nutrition education, we give the families checks so they can buy nutritious food. So they come to us because they need the food. And then we get to do all this really good stuff, like talk to them about breast feeding, talk to them about who you're going to for your doctor, is that working well, do you have Medi-Cal, do you have health insurance. We are one of those, and there was a paper that was out that WIC is a wonderful platform for school readiness.

We see ourselves out there with the moms during their pregnancy. After they've had their kids, they come to us, maybe 30 times within the first five years and we get an opportunity to do other things. The thing is we like to do these other things. We like to make sure they're going to a medical home. We like to make sure they're properly immunized. In fact, we're finding that the WIC children actually are well-immunized. The problem is getting the information. Because there is no real way that the information is shared between the provider, the health clinic, the community nurses out there…there's all kinds of disconnects.

I do have a few things I'd like to suggest. And that is, that one of the places that people drop off the health care system, I haven't heard it today but, one of things that happens is the mother can be on Medi-Cal during her pregnancy, after she delivers her baby there's a process she has to go through in order to make sure the baby is on Medi-Cal. If she doesn't do that, and it's not automatic, the baby falls off of Medi-Cal. Now that's something that should be able to be fixed. So that babies are going to be on Medi-Cal if the mother is on Medi-Cal.

The other thing I'd like to say is that WIC provides services in all kinds of languages, in all kinds of communities, we love doing education for families and we do it every time they come. But we'd like to add more literacy components. We'd like to add, and we've done a few pilot things. And we find things like if you can have a book to give a child, the child will go home with that

book clutched to their chest, it is so precious to them. We don't have the money to buy books for the kids we see.

It would be so wonderful to be able to do some things with, I didn't hear anybody mention, teenage mothers. About ten -percent of the mothers that we see are teenage mothers, so they're less prepared to do the nurturing, the support for their kids and do all the things they need to do. We need special funding to do more for the teen moms. And all teen moms need to be able to have access to more information.

We are seeing that along when you ask people about what they eat, you ask about what they drink, and sometimes what they drink is not really healthy for them. And then you need to go into how do you work with that, is it a big problem that needs to be referred to another place, or is it something that WIC, if we had time, we could talk to the mother and do a brief intervention then that could be enough for this mother.

All of these things need time and attention. In our alcohol work, we found that more than 40-percent of the mothers have clinical signs of depression. Now I've heard depression several times today, but how is a depressed mother going to either do a good job of breast feeding, nurturing her young one, is she going to read to them, is she going to feed them well even if we've given her the best information in the world? If she's depressed she may not be able to act on these things. And I think that there are links between a depressed mother and a depressed kid when it comes to school. I'm no expert but I think there must be a link.

So I think WIC is a good place to say, you know we're out there, we're in the community, we're doing a lot of good stuff. We could do more, we can't do more without more information and funding to do the special stuff.

Thank you.

Select Committee on California Children's School Readiness and Health
Fall 2001 Hearings - List of Panel Presenters

Wednesday, August 1, 2001
State Capitol – Sacramento, CA
Presenters:

- Dennis Chaconas, Superintendent of Schools, Oakland Unified School District
- Joe Coto, Superintendent of Schools, Eastside Union High School District (San Jose)
- David J. Kears, Agency Director, Alameda County Health Care Services Agency
- Irene Ibarra, CEO, Alameda Alliance for Health
- Colleen Johnson, Senior Legislative Planner and Acting Director of Policy and Planning, San Francisco Department of Public Health
- Robert Sillen, Executive Director, Santa Clara Valley Health and Hospital System
- Bob Brownstein, Policy Director, Working Partnerships USA
- Leona M. Butler, CEO, Santa Clara Family Health Plan

Thursday, November 8, 2001
Culver City, CA
Presenters:

- Dr. Neal Kaufman, Director, Division of Academic Primary Care Pediatrics, Cedars-Sinai Medical Center. Vice Chair, Los Angeles County Children and Families First - Prop 10 Commission.
- John DiCecco, Director, Los Angeles Unified School District (LAUSD) Integrated Student Health Partnerships
- Marleen Wong, Director, LAUSD Mental Health Services
- Mary View-Schneider, Co-Director of UCLA's Center for Healthier Children, Families and Communities
- Carol Valentine, Elizabeth Learning Center
- Dr. Wendy Slusser, Breast Feeding Program at UCLA
- Eloise Jenks, Public Health Foundation, Women, Infants and Children (WIC) Program
- Dr. Jackie Kimbrough, Executive Director, The Children's Collective
- Dr. M. Lynn Yonekura, Director of Development, Family Support Programs, Hope St. Family Center
- Beth Osthimer, Senior Health Policy Attorney, VIDA Project

Thursday, November 29, 2001
Salinas, CA
Presenters:

- Jack Harpster, Ed.D., Executive Director, Tellus/Díganos
- Bonnie Gutierrez, R.N. Health Services Coordinator, Pajaro Valley Unified School District
- Julie Edgcomb, Director, Member & Provider Services Central Coast Alliance for Health
- Carole Singley, R.N., Coordinator Parent Education/Health and Safety, Salinas Adult School
- Terry Espinoza Baumgart, MSW, LCSW, Coordinator of School Linked Health and Human Services,
  Alisal Community Healthy Start program, Alisal Union School District
- Jean Miner, former Executive Director of Children's Services International and Mountain Valley Family and Child Development Center
- Dr. Ray Stewart, D.M.D., M.S., Dental Director, Appolonia Foundation Children's Oral Health Program and Mobile Dental Center

Wednesday, December 5, 2001
Oakland, CA
Presenters:

- Dr. Rene Wachtel, Director, Child Development Center, Developmental and Behavioral Pediatrics, Children's Hospital Oakland
- Dr. Herbert Schreier, Director of Child Psychiatry, Children's Hospital Oakland
- Lucy S. Crain, MD,MPH, UCSF Clinical Professor of Pediatrics & Commissioner, San Francisco Children & Families Commission
- Dr. Lynne Huffman, Department of Pediatrics, Stanford University. Director, Outcomes Measurement and Research, The Children's Health Council
- Mary Claire Heffron, PhD, Psychologist, Children's Hospital Oakland
- Karla Sagramoso, PhD., Clinical Psychologist, Children's Hospital Oakland
- David Perry, DDS, Pediatric Dentist, President, California Society of Pediatric Dentists
- Jane A. Weintraub, DDS, MPH Lee Hysan Professor and Chair, Division of Oral Epidemiology and Dental Public Health Department of Preventive and Restorative Dental Sciences-University of California, San Francisco School of Dentistry
- Jared I. Fine, DDS, MPH, Dental Health Administrator, Office of Dental Health, Community Health Services Division, Alameda County Public Health Department
- Lynn Pilant, RDH, BF, Dental Program Manager, Contra Costa County

EXAMPLES OF PENDING LEGISLATION
(As of June 24, 2002)

SEAMLESS SERVICES for CHILDREN and FAMILIES

AB 47 CARDENAS School Site Parent Centers
Latest Version: Amended: 5/31/01
Status: 7/18/01 SEN EDUCATION In committee: Held without recommendation.

This bill establishes the School Site Parent Centers Facilities Program that would provide schools with permanent structures to serve as parent centers in order to improve student performance by encouraging parental involvement in their children's education. The bill would require the State Department of Education to administer the program and award one-time grants of no more than $50,000 to eligible local education agencies. The bill would require that the lowest performing 10-percent of statewide schools on the Academic Performance Index be considered first for these grants.

AB 797 SHELLEY Foster Care Providers: Educational Support Requirements.
Latest Version: Amended: 6/4/01
Status: SEN EDUCATION.

This bill states that in addition to six programs specified in statute, any county office of education, consortium of school districts in cooperation with the county office of education, or consortium of county offices of education may apply to the Superintendent of Public Instruction for grants to operate an education-based foster youth services program. This bill requires that participating entities establish a memorandum of understanding with a county welfare department regarding interaction and cooperation between the entities. Each program shall report to the Superintendent of Public Instruction on the effect of the program on achieving efficient transfer of health and educational records to child welfare agencies and on what county practices support the goals of the program. This bill also states that when the Superintendent of Public Instruction reports to the Legislature, he or she shall address the county practices that may preclude this efficient transfer. The Superintendent of Public Instruction shall also undertake ongoing evaluation of the education-based foster youth services program.

AB 892 KEELEY Healthy Start Grants
Latest Version: Amended: 7/3/01
Status: 9/6/01 SEN APPR In committee: Held under submission.

This bill states that the Superintendent of Public Instruction shall develop a process for awarding one-time strategic planning grants of up to $25,000 to local educational agencies or other groups and their Healthy Start school-community collaboratives. To be eligible to receive a strategic planning grant an applicant must be, or have been within the last three years, a Healthy Start grantee.

AB 2025 CORBETT Voluntary Working Group and Master Plan for Pupil Support Services

Latest Version: Amended: 5/1/02
Status: SEN RULES.

This bill states that the California Department of Education shall convene a voluntary working group in order to establish a master plan for pupil support services. Several different pupil service experts will be a part of this group, including school counselors, school psychologists, school nurses, librarians, school social workers, and child welfare and attendance supervisors, classroom educators, school administrators, parents or guardians, pupils, school finance experts, licensed mental health care providers, pupil financial aid experts, academic and learning support experts, and representatives from institutions of higher education that offer a credential in pupil personnel services. The group shall develop recommendations and a master plan with regards to recruiting, training, and retaining pupil support personnel, setting program standards, developing assessments, and encouraging collaboration.

AB 2311 CHU Child Care and Development Services

Latest Version: Amended: 4/30/02
Status: SEN EDUCATION.

This bill revises the definitions of "children with exceptional needs," "children with special needs," and "severely handicapped children." This bill repeals the provision that allows some child day care facilities to operate under the regulations of the California Community Care Facilities Act and allows those facilities to be exempted from State Department of Education regulations. This bill eliminates the provision that a family is eligible for state subsidized child care if the child has a medical or psychiatric need that cannot be me without child day care. This bill also repeals provisions that require the Superintendent of Public Instruction to use certain criteria to ensure geographic equity in appropriating child care and development services funds. This bill revises the needs assessment factors to be used when local planning councils assess the child care needs within their counties. This bill also makes some changes with how the local planning councils conduct their needs assessments. The bill removes provisions that would require local planning councils to consult with the State Department of Education on developing a single application and intake form for state subsidized child care and development services.

AB 2741 CHAN Children's School Readiness and Health Council

Latest Version: Amended 5/23/02
Status: SENATE RULES.

This bill establishes the Children's School Readiness and Health Council with the responsibility of developing and recommending a uniform policy to address the full range of services necessary to appropriately treat children and youth, to coordinate state programs serving children and youth, and to develop overall state priorities for serving children and youth, eliminating duplication of effort and reducing gaps in service. The duties of the council shall also include the development of a comprehensive and coordinated delivery system for services to children and youth, as well as the feasibility of moving children's programs into a State Department of

Children's Services. The council shall also establish an advisory committee on school readiness to look at children's health issues.

AB 2800 CHAN California Children and Families Commission: Duties
Latest Version: Amended: 4/16/02
Status: SEN EDUCATION.

This bill authorizes the California Children and Families Commission to allocate monies from the State fund necessary or appropriate to carry out the provisions and purposes of California Children and Families First Act of 1998, which created the commission and its responsibilities. The bill also explicitly authorizes the California Children and Families Commission to use funds for school readiness programs within specified categories.

SB 64 CHESBRO Homeless Youth Emergency Services Projects
Latest Version: Introduced 1/8/01
Status: ASM APPROPRIATIONS.

This bill states that the Office of Criminal Justice Planning shall conduct an evaluation of programs designed to serve runaway and homeless youth. It shall include demographics, agencies or sources from which youth are referred, needs of runaway and homeless youth, location of youth residences, available services (including health services), accessibility, coordination, duplication, and gaps in services, and outcomes and results of existing programs.

SB 390 ESCUTIA Child Care: Master Plan
Latest Version: Amended 7/16/01
Status: 7/16/01 Read second time. Amended. Re-referred to Committee on APPR.

This bill states that the State Department of Education shall establish and lead an oversight task force that will develop a California Child Care and Development Master Plan to guide the state's efforts to help families and local communities meet child care and development needs. The task force shall include the State Department of Social Services, the Secretary for Education, the California Children and Families Commission, local planning councils, county children and family commissions, resource and referral organizations, child care provider organizations, child care and development researchers, local governments, representatives of employers and developers, children's advocates, parent, labor and faith-based organizations, the Secretary of Health and Human Service, and the Child Development Programs Advisory Committee.

SB 1596 SCOTT Child Care: Family Support
Latest Version: Amended: 5/28/02
Status: Assembly. Held at desk.

This bill codifies, clarifies and defines current practice related to the responsibilities and requirements of alternative payment programs, which facilitate state child care and development services. This bill also proposes new fraud prevention measures and ensures the continuation of family support services provided by alternative payment programs.

SB 1661 KUEHL Disability Compensation: Family Temporary Disability Insurance
Latest Version: Amended: 5/22/02
Status: SEN APPR.

This bill states that in addition to providing disability compensation to any individual who is unable to work due to the employee's own sickness or injury, compensation will also be provided to any individual who is unable to work due to the sickness or injury of a family member, or the birth, adoption, or foster care placement of a new child. This bill establishes a family temporary disability insurance program to provide up to 12 weeks of wage replacement benefits to workers who take time off work to care for a seriously ill child, spouse, parent, domestic partner, or to bond with a new child. This bill states that the additional benefits will come from additional employee contributions, and by requiring employers to provide benefits either directly, through private insurance, or by an election to contribute to the Disability Fund.

PHYSICAL HEALTH

AB 182 VARGAS Health: Immunizations
Latest Version: Amended: 6/12/01
Status: SEN HEALTH AND HUMAN SERVICES In committee: Set first hearing. Hearing canceled at the request of author.

This bill would add Hepatitis A to the list of childhood diseases for which the Legislature intends the eventual achievement of immunization.

AB 1096 WRIGHT Pupil Health: Vision
Latest Version: Amended 9/12/01
Status: 10/22/01 To inactive file on motion of Senator Machado.

This bill would establish a three-year pilot program starting in the 2002-2003 school year that will provide comprehensive eye examinations by a licensed ophthalmologist or optometrist for poor readers identified by the school. Ten elementary and high schools that scored in the bottom 20-percent on the statewide achievement test will be selected to participate in the program. The program would be testing the value of remedial vision training and using standardized testing to see how vision training affects visual efficiency and reading progress.

AB 1793 MIGDEN Physical Education
Latest Version: Amended: 5/23/02
Status: SEN RULES.

This bill requires the State Department of Education to issue a notice of noncompliance to each school district failing to comply with certain requirements, including those regarding the number of hours of physical instruction offered to pupils in grades 1 to 12. Each school district that receives a notice of noncompliance must submit a corrective action plan in accordance with the Corrective Action Review process. The bill also requires the State Board of Education to adopt model content standards, pursuant to recommendations adopted by the Superintendent of Public Instruction, in the curriculum area of physical education. The bill appropriates $150,000 from the

General Fund to the Superintendent of Public Instruction for the purpose of developing these standards. This bill also requires each school district to report annually, at a public meeting of the governing board of the school district, its compliance with physical education requirements and the results of that physical performance test.

AB 1905 LONGVILLE Pupil Screening: Type 2 diabetes Mellitus
Latest Version: Amended: 3/11/02
Status: SEN RULES.

This bill provides for the screening of every pupil for the risk of developing type 2 diabetes mellitus in conjunction with scoliosis screenings. The screening shall be in accord with standards established by the State Department of Education. It shall be conducted by qualified supervisors of health, by school nurses, by chiropractors, or by an agency authorized to perform these services by the county superintendent of schools.

SB 606 VASCONCELLOS Pupil Health: Vision
Latest Version: Amended: 7/17/01
Status: 9/6/01 ASM APPR Set second hearing. Held in committee and under submission.

This bill requires school vision screenings that occur every three years between kindergarten and eighth grade to include binocular function, ocular alignment, ocular motility, and near visual acuity, in addition to visual acuity and color vision. If the screening reveals any vision-related problem, the individual administering the test shall provide a written statement to the child's parent or guardian stating that it may be advisable for the child to see a physician, surgeon, or optometrist.

IMPROVING ACCESS to HEALTH CARE and COVERAGE

AB 32 RICHMAN Cal-Health: Coordinating Healthy Families and Medi-Cal
Latest Version: Amended: 8/30/01
Status: 9/6/01 SEN APPR In committee: Held under submission.

This bill creates the California Health Care Program (Cal-Health). The program would work to coordinate Medi-Cal and Healthy Families in order to reduce administrative costs by streamlining resource methodologies, eligibility rules, and procedures for application, enrollment, and retention. A working group put together by the California Health and Human Services Agency would advise Cal-Health on ideas for the streamlining process. This bill allows providers to temporarily enroll eligible individuals and receive full reimbursement for the services provided during the temporary enrollment. Under Cal-Health, the department and the board would also undertake a pilot project to help small businesses in learning about providing health insurance and enrolling eligible individuals in Cal-Health.

AB 396 PAPAN Child Care: Income Eligibility
Latest Version: Amended: 7/10/01
Status: 8/20/01 SEN APPR In committee: Placed on suspense file.

This bill requires the State Department of Education to assess the impact of using regional median income in the definition of "income eligible" instead of the state median income when deciding who can enroll in subsidized child care programs.

AB 482 CEDILLO Healthy Families: Expansion
Latest Version: Amended: 7/10/01
Status: SEN INSURANCE Read second time amended and re-referred to Committee on Insurance.

This bill would expand eligibility under Healthy Families to include small employers and their employees who are otherwise eligible for the program.

AB 1525 LIU Child Care Facilities
Latest Version: Amended: 6/7/01
Status: 7/16/01 to inactive file on motion of Senator Scott.

This bill states that in a licensed child care facility where 75-percent or more of the enrollees are receiving subsidized services, additional children may only be enrolled if a waiver is recommended by an alternative payment program and then granted by the State Department of Education.

AB 1807 RICHMAN Medi-Cal and Healthy Families: Temporary Qualification and Accelerated Enrollment
Latest Version: Amended: 5/23/02
Status: SEN RULES.

This bill states that the Department of Health Services shall develop a one page joint application form that can be used to enroll a child in Medi-Cal or Healthy Families. The form shall request that a standard application for Medi-Cal or Healthy Families be completed on the child's behalf within 60 days of the first form being submitted. This bill also requires DHS to include within any statewide electronic application process for enrollment in HFP or Medi-Cal, including the Health-e-App process, the capacity for establishing a child's presumptive eligibility and initiating enrollment.

SB 59 ESCUTIA Healthy Families: Demonstration Projects
Latest Version: Amended: 1/7/02
Status: ASM HEALTH.

The bill requires the Managed Risk Medical Insurance Board (MRMIB) Healthy Families Program advisory board to consider innovative methods available under the federal program to address the needs of specifically targeted, vulnerable children, such as immigrant and homeless children.

SB 283 SPEIER Healthy Families: Payment
Latest Version: Introduced: 2/16/01

Status: 6/26/01 ASM HEALTH Set first hearing. Hearing canceled at the request of author.

This bill provides that the first full month's family contribution to Healthy Families be considered as payment in full for any fraction of a month that the subscriber was enrolled before the start of the first full month.

SB 391 McPHERSON Schools: Nurses
Latest Version: Amended: 6/29/01
Status: 9/25/01 ASM APPR.

This bill would require each County Office of Education, to the extent that sufficient funds are available, to employ a credentialed school nurse to lead and coordinate health services to pupils.

SB 785 ORTIZ Healthy Families
Latest Version: Amended 8/20/01
Status: 8/22/01 ASM APPR Set first hearing. Hearing canceled at the request of author.

This bill would expand the definition of "applicant" to the Healthy Families Program. This bill would impose a maximum contribution amount for these subscribers. It would also allow the board to pay re-enrollment fees to designated individuals and organizations if a subscriber was re-enrolled in the program based on their assistance in completing the annual eligibility review packet.

SB 1038 POLANCO Healthy Families: Immunizations
Latest Version: Amended: 7/5/01
Status: 9/6/01 ASM APPR Set second hearing. Held in committee and under submission.

This bill would enact the California Healthy Families Vaccine Purchase Act. The bill would authorize the board to allocate sufficient funds out of moneys appropriated for purposes of the Healthy Families Program to the State Department of Health Services for the purchase of covered vaccines, for the storage of covered vaccines, and for their free-of-charge distribution to qualifying practitioners.

MENTAL and EMOTIONAL HEALTH

AB 2263 KEHOE Family Court: Kids' Turn
Latest Version: Amended: 5/8/02
Status: SEN JUDICIARY.

This bill requires the Judicial Council to allocate, from funds appropriated to the Judicial Council in the annual Budget Act, the amount needed to conduct a study regarding the effectiveness of, the Kids' Turn projects, which assist children and their families while the parents are in the process of obtaining a divorce or a legal separation. The study shall consider reduction of

conflict between parents, state of child's mental health, impact on court calendars, and cost savings. Funds shall also be used to maintain current Kids' Turn projects.

AB 2740 CHAN Mental Health: State and County Plans for Children
Latest Version: Amended: 5/24/02
Status: To Senate.

This bill requires the Department of Mental Health (DMH) to convene an interagency working group to develop a state mental health plan for children. This bill also requires DMH to develop and implement a grant program to encourage each county to voluntarily develop a plan to identify and address any children's mental health services that are needed in that county.

SB 1096 ORTIZ Services for infants and toddlers with developmental disabilities
Latest Version: Amended: 1/28/02
Status: ASM HEALTH.

This bill requires that the Health and Human Services Agency, to the extent funding is received, contract for a study of early intervention services, provided through various state programs for disabled children aged 0 to 5 years, to determine if gaps in services exist and to identify options for closing service gaps.

SB 1911 ORTIZ Children's Mental Health
Latest Version: Amended: 4/22/02
Status: Assembly. Held at desk.

This bill requires the State Department of Mental Health to establish a private insurance coverage task force to identify barrier to accessing mental health care for children covered by private health insurance, whose members shall include representatives of the insurance industry, mental health stakeholders, and state departments. The State Department of Mental Health shall also determine the savings and service improvements that could result from creating an office of mental health prevention services within the department. This bill also requires the department to convene a stakeholders group and report to the Legislature on the extent to which existing categorical programs and grant programs should be merged in order to stabilize funds and improve services.

EARLY CHILDHOOD ASSESSMENTS

AB 634 WESSON Education: Minimum Age for Compulsory Attendance
Latest Version: Amended: 7/19/01
Status: 9/6/01 SEN APPR In committee: Held under submission.

This bill states that on or after July 1, 2003 each person between the ages of 5 and 18 years not otherwise exempted is subject to compulsory full-time education. An exemption is also allowed when a parent or guardian requests a waiver from the local school district for a person between the ages of 5 and 6 years.

SB 1650 ALPERT Youth Mentoring and Development Programs
Latest Version: Amended: 5/7/02
Status: Assembly. Held at desk.

This bill declares that it is a goal of the Legislature to give every young person in California access to a quality mentoring relationship and also declares legislative intent with respect to the conduct of youth mentoring programs in the state.

SB 1665 POLANCO English Learners
Latest Version: Amended: 5/29/02
Status: Assembly. Held at desk.

This bill makes legislative findings and declarations regarding limited-English-proficient pupils and would state the intent of the Legislature to integrate and restate the most basic protections in state and federal law for these pupils and their parents and to ensure sustained achievement for these pupils in the public schools. This bill also stipulates certain requirements that will help in these efforts, such as school districts assessing language skills for those students whose primary language is not English, adopting English language development instructional materials, requiring teachers to hold the correct credentials, and demonstrating student improvements in academic achievement.

NUTRITION

AB 2024 NAKANO After School Programs: Nutrition Education
Latest Version: Introduced: 2/15/02
Status: SEN EDUCATION.

This bill adds nutrition to the educational enrichment component of the Before and After School Learning and Safe Neighborhoods Partnerships Program, which now includes but is not limited to recreation and prevention activities.

AB 2395 GOLDBERG School Breakfast Program
Latest Version: Amended: 5/23/02
Status: SEN RULES.

This bill would require schools to offer breakfast through the School Breakfast Program if 20-percent or more of the school enrollment has applied and qualified for free and reduced-price meals, if the school has failed to meet its API growth target, and if the school has an API rating at or below 700.

AB 2721 CHAN Dental Health: Study
Latest Version: Amended: 5/23/02
Status: SEN RULES.

This bill would require the State Department of Health Services, in conjunction with the Department of Education, to conduct a study on children's unmet dental health needs in California, subject to receipt of private funding.